Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

THEODORE TUINSTRA
PO BOX 121589
ARLINGTON, TX 76012

Respondent Name

ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-13-0180-01

MFDR Date Received

September 20, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Rule 126.7 Designated Doctor Examinations: Request and General Procedures. This request was made in the form and manner prescribed by the Division. The report of the designated doctor is given presumptive weight regarding the issue(s) in question and/or dispute. The designated examination was requested to resolve questions(s) about the following: **Impairment caused by the employee's compensable injury Attainment of maximum medical improvement** In this case the reimbursement is not according to the Rule. When a Designated Doctor performs the MMI examination and assigns the IR but **does not** perform the range of motion, strength, or sensory testing of the musculoskeletal body area(s), that doctor should bill using the appropriate MMI CPT code with the component modifier - 26."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. LABOR CODE Section 413.011 (d). The carrier challenges whether the charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 10, 2012	CPT Code 99456-W5-26 and 99456-W5-TC	$300.00	$240.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*,applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 14, 2012

   - W1 – Workers' Compensation Jurisdictional Fee Schedule Adjustment

   Explanation of benefits dated July 16, 2012

   - W1 – Workers' Compensation Jurisdictional Fee Schedule Adjustment

Issues

1. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Requestor billed with CPT Code 99456-W5-26 and 99456-W5-TC with one unit each in the amount of $650.00 each for a testing of Maximum Medical Improvement (MMI) and Impairment Rating (IR).

   Review of the submitted documentation finds a EES-14 and DWC-032 form request for Designated Doctor Examination to address Maximum Medical Improvement (MMI) and Impairment Rating (IR) to one body area performed using Range of Motion method.

   CPT Code 99456-W5-26 is supported in accordance with 28 Texas Administrative Code §134.204 (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows, (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350, (4) The following applies for billing and reimbursement of an IR evaluation, (ii) The MAR for musculoskeletal body areas shall be as follows, (II) If full physical evaluation, with range of motion, is performed, (-a-) $300 for the first musculoskeletal body area; (-b-) $150 for each additional musculoskeletal body area and (iv) If, in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment), the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26." Reimbursement shall be 80 percent of the total MAR.

   The Total MAR for CPT Code 99456-W5-26 is $520.00.

   CPT Code 99456-W5-TC is not supported. Per 28 Texas Administrative Code §134.204 (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows, (3) The following applies for billing and reimbursement of an MMI evaluation, (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350, (4) The following applies for billing and reimbursement of an IR evaluation, (ii) The MAR for musculoskeletal body areas shall be as follows, (II) If full physical evaluation, with range of motion, is performed, (-a-) $300 for the first musculoskeletal body area; (-b-) $150 for each additional musculoskeletal body area and (v) If a HCP, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the HCP shall bill using the appropriate MMI CPT code with modifier "TC." In accordance with §130.1 of this title, the HCP must be certified. Reimbursement shall be 20 percent of the total MAR.

   Therefore, CPT Code 99456-W5-TC reimbursement is not allowed.

2. The respondent issued payment in the amount of $280.00 for CPT Code 99456-W5-26. Based upon the documentation submitted, additional reimbursement in the amount of $240.00 is recommended for CPT Code 99456-W5-26.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $240.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		8/13/13
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.